



SENIOR & LONG TERM CARE DIVISION COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE POLICY MANUAL

Section: Forms

**Subject: PERS Referral Form
SLTC - 241**

PURPOSE:

The Personal Emergency Response System (PERS) Referral Form is used to refer an approved CFC member to a PERS Provider and provide the PERS provider with the prior authorization number that is necessary in order for the PERS provider to bill for the service. This is a sample form. This form may be tailored to fit the needs of the provider agency. The form must include the requested information included on this sample.

This form should not be completed until a prior authorization number has been generated by Xerox. Prior to completing this form the provider agency Plan Facilitator must complete SLTC – 240 and submit it to MPQH to generate a PERS prior authorization number.

This form is completed by the provider agency Plan Facilitator to provide PERS providers with information in the following situations:

1. Referral of a member for PERS services by a Plan Facilitator or DD Case Manager.
2. Documentation by a Case Manager of a change in PERS services from HCBS to CFC. (PERS reimbursement should be removed from the HCBS cost sheet once the CFC prior authorization is completed in order to avoid duplication of services).
3. Change of PERS Provider.
4. Notification of a renewal of prior authorization (occurring every 365 days.) Renewals must occur in a timely manner to avoid provider claim denial and possible disruption of PERS services. Prior Authorizations will not be back dated due to missed renewal dates.
5. Termination of CFC services.

INSTRUCTIONS:

The Plan Facilitator must complete the following (Check appropriate box indicating the following action is occurring):

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1. CFC Initial Referral
2. Prior Authorization Renewal
3. Change of PERS Provider
4. Service Termination/Date

Enter: Agency Name
Plan Facilitator Name
Agency Address
Agency Phone Number
FAX Number
PERS Provider Name
PERS Provider Medicaid ID #
Member's Name
Member's Phone Number
Member's Medicaid ID Number
Member's Birth Date
Member's Address
Physician Name
Physician Phone Number
Primary Diagnosis
Diagnosis Code
Prior Authorization Number
Date Span

Enter Information on the appropriate line:

1. PERS Installation
2. PERS Rental

Enter: Appropriate modifier.

Note: Agency Based PERS services do not
require the use of a modifier for billing.

Enter: Current Units.

Unit = 1 month of service
or
Unit = 1 installation charge

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The current units should cover the number of units for the service authorization period. If the member is beginning PERS in the middle of the service year, the number of units should be pro-rated to the number of months left before the next annual member visit.

For example: 12 months = 12 units
 January – July = 7 units

Corrected Units: If the unit amount has been modified during a service year and on the same service authorization number, the correct unit number should be entered in this box.

Enter Rates: Plan Facilitators should contact the PERS provider and determine the market rate for service. Enter the market rate here, NOT the maximum rate listed on the CFC Medicaid Fee schedule.

Effective date of service: This date should not precede the MPQH authorization date.

Comments: Enter any necessary comments.

Notification of
Service

Termination: This section is completed by the Plan Facilitator in the event of a change of PERS providers or if the CFC member is discharged from services.

NOTE: The Plan Facilitator should remind the member/personal representative or family members that the PERS equipment should be returned to the PERS provider after termination of the member's PERS services.

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Distribution: Copy of this form should be retained by
the Plan Facilitator in the member files.